The Use of Benchmarks for Payment in Medicare Advantage and Necessary Adjustments

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BETTER MEDICARE ALLIANCE

Key Takeaways

- Benchmarks are the annual established maximum payments set by the CMS that health plans bid against to provide coverage of Medicare Part A and Part B services for Medicare beneficiaries.
- The benchmark is the average spending for Traditional FFS Medicare per beneficiary by county which is also adjusted for geography. Rural counties with low Medicare spending typically have a higher benchmark than average and urban districts with higher Medicare spending typically have lower benchmarks.
- When bids are lower than the benchmark, health plans receive a rebate for a portion of the difference that is used for supplemental benefits.

BMA Recommendations

BMA urges CMS and Congress to make the necessary adjustment to address the benchmark cap and the inaccuracy in the calculations to enable access to supplemental benefits for all eligible beneficiaries and preserve the high-quality care, beneficiary cost savings, and innovative benefits offered under Medicare Advantage.

Medicare Advantage plans receive monthly capitated payments to provide health care to enrollees. The Centers for Medicare & Medicaid Services (CMS) determines the maximum per beneficiary prospective monthly payment that could be paid to a health plan. The benchmark is based on the average spending per beneficiary in Traditional Fee-For-Service (FFS) Medicare, adjusted for the service area. Counties are divided into quartiles, with benchmarks ranging from 95 percent of Traditional FFS Medicare spending, typically in urban counties, to 115 percent, typically in rural counties. The higher benchmarks are intended to encourage health plan participation. Lower benchmarks in the higher spending areas are intended to contain spending.

Health plans bid against the benchmarks using their own assessment of the cost of providing all Part A and Part B benefits to enrollees and competition in the marketplace. Beneficiaries pay higher premiums if they select plans that bid higher than the benchmark. When the bid is below the benchmark, which is most common, a portion of the difference, called the rebate, goes to the health plan. Rebate dollars must be used to directly benefit the enrollees, including lowering beneficiary out-of-pocket cost-sharing and premiums, care enhancements, and additional supplemental benefits.

Payments are also adjusted based on the quality performance of the health plan under the Star Ratings System. These adjustments are called Quality Bonus Payments (QBPs). Rebate amounts differ based on a plan's Star Rating and range from a 50 percent rebate for plans with 3 or fewer stars to 70 percent for plans with 4.5 or 5 stars. High-quality 4-and 5-Star health plans receive a 5-percentage point quality adjustment to the benchmark. In counties with low Traditional FFS Medicare expenditures and high Medicare Advantage enrollment, known as "double bonus counties," the benchmark is increased by ten percentage points for these high performing health plans. In 2021, 77 percent of beneficiaries are expected to be enrolled in high-quality, 4-and 5-Star health plans as of 2021.

Medicare Advantage Benchmark Cap

A cap on benchmarks was established as a cost containment measure to keep payments from rising above the amount of the benchmark set in 2008. Known as the "benchmark cap," this policy makes high quality health plans with four or more stars in certain counties ineligible for the entire QBP. Health plans that would have been eligible for a bonus payment do not receive the full quality incentive if they are in a county that is capped. The result is that beneficiaries in those high quality health plans do not have access to the extra benefits or lower cost-sharing due to geography.

Inaccuracy in Medicare Benchmarks

Benchmarks are calculated using the spending of all Traditional FFS Medicare beneficiaries. This includes those individuals that are enrolled only in Part A or only in Part B. Yet benefits in Medicare Advantage must cover benefits under both Part A and Part B. Including the spending on only some of these benefits results in inaccuracy of the average spending that is the basis of the benchmark. Policymakers agree this should be addressed by using only the spending for individuals with both Part A and Part B for the calculation of the benchmark.

Conclusion

Medicare Advantage benchmarks are set using a robust methodology that maintains the guarantee of benefits available to all Medicare beneficiaries, keeps spending for the government for Medicare Advantage at or below the cost of Traditional FFS Medicare, and encourages competition between health plans to lower costs, add extra benefits and meet high quality standards, without additional spending by the federal government. QBPs incentivize quality performance and ensure that those payments are used to directly benefit enrollees. Most recently these benefits may also be used to address social determinants of health. Even with QBPs, there is now payment parity between Medicare Advantage and Traditional FFS Medicare.